

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION# 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>160</u>	Skilled (SNF)	<u>160</u>	<u>58,560</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>71</u>	Intermediate (ICF)	<u>71</u>	<u>25,986</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>231</u>	TOTALS	<u>231</u>	<u>84,546</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>33,336</u>	<u>6,496</u>	<u>5,391</u>	<u>45,223</u>	8
9	SNF/PED					9
10	ICF	<u>14,287</u>	<u>2,784</u>	<u>2,311</u>	<u>19,382</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>47,623</u>	<u>9,280</u>	<u>7,702</u>	<u>64,605</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.41%D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 05/01/95J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/01/95 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 42 and days of care provided 3,231Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION** # **0044081** Report Period Beginning: **01/01/00** Ending: **12/31/00**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	A. General Services											1
1	Dietary	246,728	27,367	8,060	282,155		282,155		282,155			1
2	Food Purchase		260,873		260,873	(50,911)	209,962	(372)	209,591			2
3	Housekeeping	185,914	36,953		222,867		222,867		222,867			3
4	Laundry	72,441	30,418		102,859		102,859		102,859			4
5	Heat and Other Utilities			175,324	175,324		175,324		175,324			5
6	Maintenance	61,238	30,465	55,629	147,332		147,332	(3,457)	143,875			6
7	Other (specify):*											7
8	TOTAL General Services	566,321	386,076	239,013	1,191,410	(50,911)	1,140,499	(3,829)	1,136,671			8
9	B. Health Care and Programs											
9	Medical Director			17,000	17,000		17,000		17,000			9
10	Nursing and Medical Records	1,878,186	84,258	128,395	2,090,839		2,090,839		2,090,839			10
10a	Therapy	91,755		12,672	104,427		104,427		104,427			10a
11	Activities	89,572	17,119	3,440	110,131		110,131		110,131			11
12	Social Services	107,313		4,199	111,512		111,512		111,512			12
13	Nurse Aide Training			420	420		420		420			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,166,826	101,377	166,126	2,434,329		2,434,329		2,434,329			16
17	C. General Administration											
17	Administrative	106,931		150,000	256,931		256,931		256,931			17
18	Directors Fees											18
19	Professional Services			125,473	125,473		125,473	(60,435)	65,038			19
20	Dues, Fees, Subscriptions & Promotions			129,551	129,551		129,551	(91,253)	38,298			20
21	Clerical & General Office Expenses	98,066	40,396	63,632	202,094		202,094	(12,840)	189,254			21
22	Employee Benefits & Payroll Taxes			454,061	454,061	50,911	504,972	(7,932)	497,040			22
23	Inservice Training & Education											23
24	Travel and Seminar			22,106	22,106		22,106	(300)	21,806			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			149,556	149,556		149,556		149,556			26
27	Other (specify):*											27
28	TOTAL General Administration	204,997	40,396	1,094,379	1,339,772	50,911	1,390,683	(172,760)	1,217,923			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,938,144	527,849	1,499,518	4,965,511		4,965,511	(176,589)	4,788,922			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

PEBBLEBROOK NURSING & REHABILITATION

0044081

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	<u>50,911</u>	
2	FOOD		<u>50,911</u>

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	<u> </u>	
19	PROFESSIONAL FEES		<u> </u>

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			29,732	29,732		29,732	64,393	94,125			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,993	171,993		171,993	(9,503)	162,490			32
33	Real Estate Taxes			125,254	125,254		125,254		125,254			33
34	Rent-Facility & Grounds			1,277,049	1,277,049		1,277,049		1,277,049			34
35	Rent-Equipment & Vehicles			51,305	51,305		51,305	(11,126)	40,179			35
36	Other (specify):*											36
37	TOTAL Ownership			1,655,333	1,655,333		1,655,333	43,764	1,699,097			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,126	165,040	261,166		261,166		261,166			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,819	126,819		126,819		126,819			42
43	Other (specify):*	41,981			41,981		41,981	(41,981)				43
44	TOTAL Special Cost Centers	41,981	96,126	291,859	429,966		429,966	(41,981)	387,985			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,980,125	623,975	3,446,710	7,050,810		7,050,810	(174,806)	6,876,004			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**Report Period Beginning: **01/01/00**Ending: **12/31/00****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	64,393	30		9
10	Interest and Other Investment Income	(3,703)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(372)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(749)	21		18
19	Entertainment				19
20	Contributions	(1,695)	19		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,091)	21		24
25	Fund Raising, Advertising and Promotional	(79,633)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(10,966)	20		28
29	Other-Attach Schedule	(129,990)	VAR		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (174,806)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (174,806)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
PEBBLEBROOK NURSING & REHABILITATION

Page 5A

Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$	6
2	FRANCHISE TAX	(520)	20
3	MARKETING SALARIES	(41,981)	43
4	MARKETING SEMINAR EXPENSE	(20)	24
5	1999 TOYOTA CAMRY	(3,720)	35
6	1997 ACURA RL	(6,660)	35
7	RENTAL CARS	(746)	35
8	IL COUNCIL ON LTC COPE CONTRIBUTION	(134)	20
9	MARKETING	(21,850)	19
10	OUT OF STATE TRAVEL	(270)	24
11	PRIOR-EMPLOYEE BENEFITS	(7,932)	22
12	PRIOR-INTEREST ACCRUAL	(5,800)	32
13	LEGAL	(33,290)	19
14	PROFESSIONAL FEES	(3,600)	19
15	CAPITALIZED R&M	(3,457)	6
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
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76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(129,990)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(372)											(372)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(3,457)											(3,457)	6
7	Other (specify):*													7
8	TOTAL General Services	(3,829)											(3,829)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(60,435)											(60,435)	19
20	Fees, Subscriptions & Promotions	(91,253)											(91,253)	20
21	Clerical & General Office Expenses	(12,840)											(12,840)	21
22	Employee Benefits & Payroll Taxes	(7,932)											(7,932)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(300)											(300)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(172,760)											(172,760)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(176,589)											(176,589)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V						\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V							\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V						\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PEBBLEBROOK NURSING & REHABIL # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JONAH BRUCK	OWNER	ADMIN	20.00%	0	30	75.00%	MGMT FEE	\$ 75,000	17-3	1
2								SALARY	25,137	17-1	2
3	LEONARD WEISS	OWNER	ADMIN	20.00%	0	35	87.00%	MGMT FEE	75,000	17-3	3
4								SALARY	39,808	17-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 214,945		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION** # **0044081** Report Period Beginning: **01/01/00** Ending: **12/31/00**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	SUCCESS NATIONAL BANK			LINE OF CREDIT		07/31/00		378,639	08/01/01	PRIME +.5%	1,072		6
7	SUCCESS NATIONAL BANK			LINE OF CREDIT		07/31/00		1,330,821	08/01/05	PRIME +.5%	70,526		7
8													8
9	TOTAL Facility Related						\$	1,709,460			\$	71,598	9
	B. Non-Facility Related*												
10	Supplemental Schedule										90,892		10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	90,892	14
15	TOTALS (line 9+line14)						\$	1,709,460			\$	162,490	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITA'# 0044081

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
1	BRICKYARD BANK #4740						\$					\$	64,939	1
2	BRICKYARD BANK #4741		X	LINE OF CREDIT									10,425	2
3	BRICKYARD BANK #4742		X	LINE OF CREDIT									6,138	3
4	BRICKYARD BANK #5012												8,162	4
5	BANK OF LINCOLNWOOD		X	LINE OF CREDIT									3,958	5
6	MBNA AMERICA		X	LINE OF CREDIT									973	6
7	INTEREST INCOME												(3,703)	7
8														8
9														9
10														10
11														11
12														12
13														13
14														14
15														15
16														16
17														17
18														18
19														19
20														20
21							\$		\$			\$	90,892	21

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	129,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	127,577	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(2,323)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	127,577	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	125,254	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	73,377	8
	1996	118,424	9
	1997	123,151	10
	1998	84,650	11
	1999	127,577	12

ACCRUAL=1999 REAL ESTATE TAX BILL

	FOR OHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION

0044081

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,658 B. General Construction Type: Exterior Frame BRICK Number of Stories 3

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1995		9,573		20	753	753	4,214	9
10	ELEVATOR WORK		1996		2,660		20	133	133	654	10
11	SINK LINE REPAIR		1996		4,250		20	213	213	870	11
12	PAINT AND WALLPAPER		1996		65,937		20	3,297	3,297	14,012	12
13	BLACKTOP		1996		6,600		20	330	330	1,403	13
14	PAINT AND WALLPAPER		1996		40,000		20	2,000	2,000	8,167	14
15	CARPETING		1997		14,781		20	739	739	2,894	15
16	PAINT & WALLPAPER		1997		10,000		20	500	500	1,875	16
17	KITCHEN DRAIN WORK		1997		2,200		20	110	110	394	17
18	HEAT EXCHANGER		1997		2,059		20	103	103	369	18
19	A/C WORK		1997		1,770		20	89	89	319	19
20	PAINT & WALLPAPER		1997		51,515		20	2,576	2,576	10,089	20
21	METRON CONSTR.		1998		47,501		20	2,375	2,375	6,531	21
22	SECURITY SYSTEM		1998		3,140	81	20	157	76	366	22
23	OUTSIDE SPRINKLER		1998		2,908	75	20	145	70	338	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				117,961	3,811		4,850	1,039	5,264	34
35	PAGE 12A TOTALS				109,828	1,744		5,493	3,749	12,097	35
36	TOTAL (lines 4 thru 35)				\$ 492,683	\$ 5,711		\$ 23,863	\$ 18,152	\$ 69,856	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		COOLING TOWER PIPE		1998	2,610	67	20	131	64	328	9
10		CO DETECTOR		1998	1,585	41	20	79	38	178	10
11		MAIN WATER LINE		1998	1,453	37	20	73	36	164	11
12		SECURITY FENCE		1998	5,575	143	20	279	136	628	12
13		PARKING LOT		1998	12,350	317	20	618	301	1,339	13
14		PUBLIC BATHROOMS		1998	5,000	128	20	250	122	521	14
15		SUB ACUTE ROOMS		1998			20				15
16		AIR HANDLER, BOILER		1998	10,740	275	20	537	262	1,253	16
17		DAMPER DRYWALL		1998	3,500	90	20	175	85	394	17
18		LANDSCAPING		1998	34,110		20	1,706	1,706	4,549	18
19		A/C CHILLER		1998	4,885	125	20	244	119	569	19
20		COOLING TOWER PIPE		1998	1,428	37	20	71	34	166	20
21		SPEAKER SYSTEM		1999	997	26	20	50	24	67	21
22		HVAC		1999	825		20	41	41	62	22
23		SPRINKLERS FOR GRASS		1999	1,280	33	20	64	31	128	23
24		FURNACE		1999	1,000	26	20	50	24	92	24
25		GENERATOR		1999	595		20	30	30	45	25
26		ELEVATOR DOOR REPAIR		1999	4,609		20	230	230	345	26
27		ROOF EXHAUST		1999	2,100	54	20	105	51	123	27
28		SHOWER & TUB VALVES		1999	726	19	20	36	17	54	28
29		FURNACE		1999	2,010	52	20	101	49	135	29
30		SIGN FACES		1999	1,800		20	90	90	135	30
31		DINING ROOM REMODEL		1999	974		20	49	49	74	31
32		PAINTING & DECORATIN		1998	5,242		20	262	262	393	32
33		SEWER PUMP REPAIR		1999	1,742		20	87	87	131	33
34		BANNERS		1999	857	274	20	43	(231)	86	34
35		25 HP BLOWER MOTOR		1999	1,835		20	92	92	138	35
36		TOTAL (lines 4 thru 35)			\$ 109,828	\$ 1,744		\$ 5,493	\$ 3,749	\$ 12,097	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SEWAGE EJECTOR PUMP		1999	1,742		20	87	87	131	9
10		SEAL COAT PARKING LO		1999	1,365	35	20	68	33	108	10
11		PHONE CABLE & JACKS		1999	786		20	39	39	59	11
12		PAINTING & ELECTR.		1999	925	24	20	46	22	92	12
13		PARKING LOG SIGN		1999	2,748	879	20	137	(742)	251	13
14		ROOM SIGN		1999	2,410	771	20	121	(650)	232	14
15		OUTLET AND ANTENNA		1999	925		20	46	46	69	15
16		FURNACE		1999	1,860	48	20	93	45	109	16
17		CEILING DIFUSERS		2000	1,000	18	20	38	20	38	17
18		DISMANTLE AIRHANDLER		2000	1,620	26	20	54	28	54	18
19		REPLACE FLOOR DRAIN		2000	2,700	9	20	23	14	23	19
20		NURSES STATION		2000	11,000	247	20	504	257	504	20
21		DINING ROOMS		2000	37,575	843	20	1,722	879	1,722	21
22		CLOSETS & WALLS		2000	21,800	443	20	908	465	908	22
23		CARD ACCESS SYSTEM		2000	10,390	211	20	433	222	433	23
24		TILE & GROUT		2000	765	18	20	35	17	35	24
25		AIRHANDLER		2000	4,565	73	20	152	79	152	25
26		WALLPAPER & PAINT		2000	10,329	166	20	344	178	344	26
27		CHILLER COIL PIPING		2000	910		20				27
28		FIRE RATED DOOR		2000	790		20				28
29		AC MOTOR		2000	621		20				29
30		ELEVATOR DOOR CABLES & GIBS		2000	1,135		20				30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 117,961	\$ 3,811		\$ 4,850	\$ 1,039	\$ 5,264	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
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28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
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14											14	
15											15	
16											16	
17											17	
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29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
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29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
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15											15	
16											16	
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29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
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29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
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18												17
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29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
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14											14	
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30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
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28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
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17											17	
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28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
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29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION** # **0044081**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 648,832	\$ 15,172	\$ 64,887	\$ 49,715		\$ 238,525	37
38	Current Year Purchases	67,733	8,849	5,375	(3,474)		5,375	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 716,565	\$ 24,021	\$ 70,262	\$ 46,241		\$ 243,900	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,209,248	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 29,732	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 94,125	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 64,393	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 313,756	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

PEBBLEBROOK NURSING & REHABILITATION
0044081
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
PEBBLE BROOK NURSING & REHABILITATION CENTRE, LLC	648,832	15,172	64,887	49,715	238,525
TOTALS	648,832	15,172	64,887	49,715	238,525

LINE 29: CURRENT YEAR

PEBBLE BROOK NURSING & REHABILITATION CENTRE, LLC	67,733	8,849	5,375	(3,474)	5,375
TOTALS	67,733	8,849	5,375	(3,474)	5,375

LINE 30: FULLY DEPRECIATED

PEBBLE BROOK NURSING & REHABILITATION CENTRE, LLC					
TOTALS					

TOTALS (Should Tie to Totals on Page 13)

PEBBLE BROOK NURSING & REHABILITATION CENTRE, LLC	716,565	24,021	70,262	46,241	243,900
TOTALS	716,565	24,021	70,262	46,241	243,900

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION**# **0044081**

Report Period Beginning:

01/01/00Ending: **12/31/00****XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: **K.B.C. HEALTH CENTER**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		231		\$ 1,277,049			3
4	Additions							4
5								5
6								6
7	TOTAL		231		\$ 1,277,049			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☒ YES ☐ NO Terms: **AFTER 11/01/05 \$13,282,500** ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO16. Rental Amount for movable equipment: \$ **26,572**Description: **FLR MACH=\$713, COPR=\$8,031, POST MTR=\$1,498, SEC CAM=\$1,636, BED=\$13,639, WHLCHR=\$1,055**
(Attach a schedule detailing the breakdown of movable equipment)**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	BUSINESS	1998 ACURA RL	\$ 634.03	\$ 7,608	17
18	BUSINESS	2000 NISSAN PATHFINDER	499.89	5,999	18
19					19
20					20
21	TOTAL		\$ #####	\$ 13,607	21

10. Effective dates of current rental agreement:

Beginning **08/01/98**Ending **04/30/08**11. Rent to be paid in future years under the current
rental agreement:

Fiscal Year Ending Annual Rent

12.	05/01/01	\$ 1,264,725
13.	05/01/02	\$ 1,285,804
14.	05/01/03	\$ 1,306,883

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Facility Name & ID Number **PEBBLEBROOK NURSING & REHABILITATION** # **0044081** Report Period Beginning: **01/01/00** Ending: **12/31/00**
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input checked="" type="checkbox"/> HOURS PER AIDE <u>32</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>12</u>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 420	\$	\$ 420
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 420	\$	\$ 420
10	SUM OF line 9, col. 1 and 2 (e)	\$ 420			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>1</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39-3	hrs	\$		
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,913				6,913	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs			99,151				99,151	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts				65,811			65,811	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**	39-2, 39-3					30,316			30,316	13
14	TOTAL			\$		\$ 165,039	\$ 96,127		\$	261,166	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 AIR FLUIDIZED BED	150
2 MEDICAL SUPPLIES	28,686
3 LABORATORY	1,480
4	
5	
6	
7	
8	
9	
10	
	<u>30,316</u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u></u>
	<u></u>

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 3,165	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	970,340		3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	67,120		6
7 Other Prepaid Expenses	83,979		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): See supplemental schedule	138,921		9
TOTAL Current Assets			
10 (sum of lines 1 thru 9)	\$ 1,263,525	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cos	195,087		15
16 Equipment, at Historical Cost	141,443		16
17 Accumulated Depreciation (book methods)	(56,176)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):	1,039,500		22
23 Other(specify): See supplemental schedule	100,845		23
TOTAL Long-Term Assets			
24 (sum of lines 11 thru 23)	\$ 1,420,699	\$	24
TOTAL ASSETS			
25 (sum of lines 10 and 24)	\$ 2,684,224	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 468,076	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	20		28
29 Short-Term Notes Payable	378,639		29
30 Accrued Salaries Payable	199,410		30
31 Accrued Taxes Payable (excluding real estate taxes)	9,365		31
32 Accrued Real Estate Taxes(Sch.IX-B)	127,577		32
33 Accrued Interest Payable	10,260		33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 See supplemental schedule			36
37			37
TOTAL Current Liabilities			
38 (sum of lines 26 thru 37)	\$ 1,193,347	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	1,330,821		39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 See supplemental schedule			43
44			44
TOTAL Long-Term Liabilities			
45 (sum of lines 39 thru 44)	\$ 1,330,821	\$	45
TOTAL LIABILITIES			
46 (sum of lines 38 and 45)	\$ 2,524,168	\$	46
TOTAL EQUITY (page 18, line 24)	\$ 160,056	\$ #REF!	47
TOTAL LIABILITIES AND EQUITY			
48 (sum of lines 46 and 47)	\$ 2,684,224	\$ #REF!	48

*(See instructions.)

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION

0044081

Report Period Beginning: 01/01/00

Ending:

12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

REAL ESTATE TAX ESCROW

INSURANCE ESCROW

DUE TO/FROM RELATED PARTY

EMPLOYEE ADVANCES

Amount

116,254

14,978

1,817

5,872

Amount

OTHER CURRENT LIABILITIES:

Amount

Amount

138,921

OTHER NON CURRENT ASSETS:

REPLACEMENT RESERVE

100,845

OTHER NON CURRENT LIABILITIES:

100,845

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 199,665	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 199,665	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(39,609)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (39,609)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 160,056	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number	PEBBLEBROOK NURSING & REHAI#	0044081	Report Period Beginning:	01/01/00	Ending:	12/31/00
---------------------------	------------------------------	---------	--------------------------	----------	---------	----------

Balance per General Ledger	199,665
----------------------------	---------

Adjustments:

-
-
-

Total adjustments

-

Balance - Beginning of Year

199,665

Equity(Deficit) from Page 17 Col 1

160,056

Related Party

Equity(Deficit)

0

Income

0

-

Combined Equity - End of Year

160,056

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION # 0044081 Report Period Beginning: 01/01/00

Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,216,859	1
2	Discounts and Allowances for all Levels	(878,459)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,338,400	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	507,890	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 507,890	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	161,208	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 161,208	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,703	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,703	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,011,201	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,191,410	31
32	Health Care	2,434,329	32
33	General Administration	1,339,772	33
	B. Capital Expense		
34	Ownership	1,655,333	34
	C. Ancillary Expense		
35	Special Cost Centers	303,147	35
36	Provider Participation Fee	126,819	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,050,810	40
41	Income before Income Taxes (line 30 minus line 40)**	(39,609)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (39,609)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 Vending Commissions	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION

0044081

Report Period Beginning:

01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,004	2,117	\$ 74,381	\$ 35.14	1
2	Assistant Director of Nursing	1,866	2,013	44,092	21.90	2
3	Registered Nurses	35,584	39,217	750,430	19.14	3
4	Licensed Practical Nurses	8,664	9,023	147,392	16.34	4
5	Nurse Aides & Orderlies	86,062	91,429	795,618	8.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,166	9,092	91,755	10.09	8
9	Activity Director	1,823	2,059	19,270	9.36	9
10	Activity Assistants	10,640	11,237	70,302	6.26	10
11	Social Service Workers	4,839	5,028	107,313	21.34	11
12	Dietician					12
13	Food Service Supervisor	1,946	2,150	41,688	19.39	13
14	Head Cook	5,280	5,982	57,432	9.60	14
15	Cook Helpers/Assistants	19,489	21,013	147,608	7.02	15
16	Dishwashers					16
17	Maintenance Workers	5,245	5,555	61,238	11.02	17
18	Housekeepers	26,588	28,372	185,914	6.55	18
19	Laundry	9,898	10,804	72,441	6.71	19
20	Administrator	2,047	2,091	25,137	12.02	20
21	Assistant Administrator	1,854	1,887	41,986	22.25	21
22	Other Administrative	2,080	2,080	39,808	19.14	22
23	Office Manager					23
24	Clerical	6,701	7,031	98,066	13.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,997	5,424	66,273	12.22	31
32	Other Health Care(specify)					32
33	Other(specify)	1,818	1,930	41,981	21.75	33
34	TOTAL (lines 1 - 33)	247,591	265,534	\$ 2,980,125 *	\$ 11.22	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	18	\$ 8,060	1-3	35
36	Medical Director	12	17,000	9-3	36
37	Medical Records Consultant	12	4,032	10-3	37
38	Nurse Consultant	330	18,763	10-3	38
39	Pharmacist Consultant	12	2,520	10-3	39
40	Physical Therapy Consultant	97	4,850	10A-3	40
41	Occupational Therapy Consultant	148	7,772	10A-3	41
42	Respiratory Therapy Consultant	1	50	10A-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	54	3,440	11-3	44
45	Social Service Consultant	83	4,199	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	767	\$ 70,686		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	680	\$ 24,760	10-3	50
51	Licensed Practical Nurses	1,559	50,516	10-3	51
52	Nurse Aides	1,557	27,804	10-3	52
53	TOTAL (lines 50 - 52)	3,796	\$ 103,080		53

A. Administrative Salaries			
Name	Function	% Ownership	Amount
JONAH BRUCK	ADMINISTRATOR	20.00%	\$ 25,137
YOEL GRUN	ASST ADMINISTRATOR	NONE	15,115
	01/01/00-04/22/00		
AARON NOTTERMAN	ASST ADMINISTRATOR	NONE	26,871
	05/30/00-12/31/00		
LEONARD WEISS	ADMINISTRATION	20.00%	39,808
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 106,931
B. Administrative - Other			
Description			Amount
JONAH BRUCK-MANAGEMENT FEES			\$ 75,000
LENNIE WEISS-MANAGEMENT FEES			75,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 150,000
C. Professional Services			
Vendor/Payee	Type		Amount
SEE ATTACHED			\$ 125,473
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 125,473
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 46,228
Unemployment Compensation Insurance			32,799
FICA Taxes			227,980
Employee Health Insurance			108,548
Employee Meals			50,911
Illinois Municipal Retirement Fund (IMRF)*			
CHRISTMAS EXPENSE			13,794
EMPLOYEE BENEFITS			16,778
TOTAL (agree to Schedule V, line 22, col.8)			\$ 497,038
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			21,907
Health Care Worker Background Check (Indicate # of checks performed 123)			1,314
YELLOW PAGE ADVERTISING			10,966
PROMOTIONAL ADVERTISING			79,633
LICENSE AND FEES			4,256
DUES AND SUBSCRIPTIONS			9,126
CONTRIBUTIONS			1,695
Less: Public Relations Expense			()
Non-allowable advertising			(79,633)
Yellow page advertising			(10,966)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 38,298
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			13,862
Seminar Expense			7,944
Entertainment Expense			()
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 21,806

*** Attach copy of IMRF notifications**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number PEBBLEBROOK NURSING & REHABILITATION

0044081

Report Period Beginning: 01/01/00

Ending: 12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LTC=\$8,006
- (3) Did the nursing home make political contributions or payments to a political organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over T.J.O.I. LAKE KNOLL HEALTHCARE 05/01/98 #40873
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 126,819
This amount is to be recorded on line 42 of Schedule V _____
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 50,911 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw